Integrated Care Partnership

14.00 to 16.00, Thursday 8 February 2024

Venue: Bromley Central Library High St, Bromley BR1 1EX

Co-Chairs:
Richard Douglas (RD) – Chair, South East London ICB
Cllr Kieron Williams (KW) - Leader, Southwark Council

Agenda

No.	Item	Paper	Lead	Timing
	OPEN 14.00			
1.	**Welcome and introduction – opening business.** *Receive apologies.* **Minutes of the previous meeting** *Minutes of the meeting on 26 October 2023 for acceptance as a record.* **Matters Arising**	**A**	RD	14.00
2.	**Update on Social care** *Current state of social care services in south east London and a look ahead to the coming year.*	**B**	SR/PT/ ND	14.15
3.	**Our Integrated Care Strategy** *Plans for implementation of initiatives towards the delivery Integrated Care Strategy Priorities.*	**C**	AB/ BC/ SC/	14.45
4.	**Questions from the public** *An opportunity for questions from members of the public.*	**-**	RD	15:45
	CLOSE 16.00			

Presenter

SC	Sarah Cottingham	ICB Director of Commissioning and Improvement
SR	Stuart Rowbotham	Place Executive Lead for Bexley and DASS
TG	Dr Toby Garrood	ICB Chief Medical Officer
AB	Andrew Bland	ICB CEO
RD	Richard Douglas	ICP Co-Chair
PT	Peter Turner	London Borough of Bromley
ND	Nick Davies	Royal Borough of Greenwich
BC	Ben Collins	Director of ICS Development

DRAFT

Integrated Care Partnership

Minutes of the meeting on 26 October 2023
Assembly Room - Lambeth Town Hall, 1 Brixton Hill, London SW2 1RW

Present:

Name	Title and organisation
Cllr Kieron Williams [Chair]	Leader of Southwark Council
Richard Douglas	Chair, NHS South East London ICB
Andrew Bland	Chief Executive Officer, NHS South East London ICB
Sarah Cottingham	Deputy CEO and Director of Planning, NHS South East London ICB
Cllr Jim Dickson	Cabinet Member for Healthier Communities, LB Lambeth
Tal Rosenzweig	Director of Voluntary sector collaboration and partnerships.
Dr Catherine Mbema	Director of Public Health, LB Lewisham
Michael Nutt	Chair, Bromley Healthcare CIC
Folake Segun	Director South East London Healthwatch
Sir Norman Lamb	Chair of South London and Maudsley NHS Foundation Trust
Dr Taj Singhrao	Primary Care Services Representative
Dr Helen Tattersfield	Primary Care Services Representative

In attendance

Name	Title and organisation
Maria Higson	SEL ICS Director of Transformation
Kate Jones	Deputy Director South London Office of Specialised Services (Observing)
Colin Nash	Governance Manager, NHS South East London ICB [Minutes]

1.	**Welcome**
1.01	Cllr Kieron Williams welcomed members to the meeting.
1.02	Apologies were received from Cllr Evelyn Akoto, Charles Alexander, Mike Bell, Cllr Paul Bell, Joseph Casey, Toby Garrood, Jonty Heaversedge, Jill Lockett, Cllr Anthony Okereke, Cllr Baroness Teresa O'Neill, David Quirke-Thornton, Cllr Denise Scott-McDonald and Andy Trotter.
1.03	The minutes of the meeting on 26 April 2023 were **APPROVED SUBJECT TO** the correction of minute 4.04 to read Nepalese rather than Vietnamese.
2	**Elective Care**
2.01	Sarah Cottingham gave an update on planned care and elective recovery plans in south east London, developed in collaboration with the Acute Provider Collaborative. In planning for 2023/24 the system had been asked to achieve 109% of historic 2019/20 activity, later reduced to 107% to allow for impact of industrial action. The system was also asked to maintain a position of zero waits over 104 weeks, to eliminate waits of 78 weeks by April 2023 and to eliminate waits of 65 weeks by March 2024. South east London's plan showed that the these targets would be met with the exception of 50 patients waiting for pediatric spinal services.
2.02	Currently the system was delivering 110.5% of historic activity, however there remained a small number of 104-week waiters and just over 300 patients waiting

over 78 weeks. Meeting the March 2024 target for elimination of 65-week waits would be challenging although significant progress had been made in reducing the 118,0000 65-week waits at the start of the year to 35,000 patients waiting over 65 weeks in August 2023. Reasons for outstanding 104-week waits could be summed up as delays to accommodate patient choice, complex needs in individual cases, or capacity issues in the specialty involved. Waits of 78-weeks were driven mainly by the need cancel procedures and prioritise capacity for urgent treatment during industrial action.

2.03 Improvement work was underway in mitigation, including: community based alternatives to acute care; enhanced dermatology coverage across all boroughs and work on improved pathways, a single point of access and tele-dermatology; expansion of ophthalmology services particularly for those with learning disabilities or in care homes. A comprehensive community-based Ear Nose and Throat offer was being developed and all primary care referrals would be triaged by this service. Improvements in theatre utilisation were underway to increase throughput, reduce cancellations and complete more cases within a day. Mutual aid across the system aimed to equalise the length of waits in different parts of the system, and included increased use of hubs, and use of independent sector capacity where appropriate. Across all work there were efforts to ensure equitable access by reducing unequal waits across the system, and waiting lists were being examined for inequalities in those waiting.

2.04 Challenges and risks included the impact of ongoing industrial action on the ability to maximise elective activity, competing demands for limited capacity such as urgent and emergency care during winter, the planned reduction in activity to allow Guys and St Thomas FT and Kings College Hospital FT to embed the new Epic system.

2.05 Cllr Kieron Williams noted that although the situation continued to be difficult for many patients waiting across the borough there has been some remarkable progress.

2.06 Cllr Jim Dickson paid tribute to work being done across hospital trusts, as well as joint working with councils and the VCSE to address the problem. However, the large numbers of patients waiting 65 and 78 weeks was very disappointing, and until the industrial relations issues were resolved it seemed patients would not get the service they deserved. Cllr Scott McDonald had highlighted as a factor the increasing demand on social care because of the acuity of patients in the community, asking if data might be available the scale of this impact.

2.07 Cllr Kieron Williams suggested an update on the impact of social care in the future. **Action**

2.08 Sir Norman Lamb asked whether work on theatre capacity was close to achieving maximum utilisatio, and whether opportunities to consolidate services were being taken up or whether there was resistance. He warned that allocating resources to address substantial deficits on the acute side risked unbalancing provision to disadvantage preventative services.

2.09 Sarah Cottingham noted the target is for utilisation was 85% and latest data is 77% representing a clear opportunity for improvement. Richard Douglas noted during the Covid-19 pandemic there had been a significant increase in providers working together, providing a basis for further collaboration. Andrew Bland added that the south east London Acute Provider Collaborative were working on six specialties across all trusts.

2.10 Folake Segun asked about mutual aid and collaboration being used to address inequalities. Sarah Cottingham clarified that hubs a Queen Mary's Hospital and Orpington were being run as resources available to the whole system.

2.11 Dr Helen Tattersfield noted the increased complexity of care required from general practice created a need for primary and secondary care working more closely on specific areas. Sarah Cottingham noted there a number of primary care secondary

	care joint working opportunities and work on this was being led by the medical director.
2.12	Michael Nutt suggested comparison of acute waiting list with community care and mental health waiting lists. In shifting care from hospitals to the community there was a need to be assured of sufficient capacity in the community to manage these patients appropriately. Sarah Cottingham noted that data for community services was not as mature as that available for acute but provided assurance that the services commissioned from the community sector were funded.
2.13	Andrew Bland noted that many of the areas raised would be raised at forthcoming the ICB board.
2.14	The Integrated Care Partnership **noted** the update.
3	**Final South East London Voluntary, Community and Social Enterprise (VCSE) Charter**
3.01	Andrew Bland underlined the importance of work with the VCSE sector, whilst noting that relationships and the majority of work would be delivered at Place level in each borough. The charter had been adapted to reflect comments received in engagement, and was presented for agreement.
3.02	Tal Rosenzweig summarised amendments made in the light of feedback: to set the charter in the context of the ICS's priorities around prevention and reducing inequalities; to clarify a focus on supporting grass-roots organisations; and to recognise financial stresses across the system. Some items on infrastructure had been removed and would be developed in future work on the most effective use of resources.
3.03	Cllr Keiron Williams reiterated that the common framework did not set out tp prescribe how work with the VCSE sector would develop in boroughs, who would each deliver in their own way.
3.04	Michael Nutt pointed out that large organisations such as Bromley Healthcare CIC still faced unresolved challenges in relation to money and contract negotiations.
3.05	Cllr Jim Dickson welcomed the ICSs' agreement prioritise working with the VCSE, and pointed to the variety of experience in boroughs of initiatives that worked such as the Thrive partnership in Lambeth. It would be important to learn from the work already taking place. He suggested a minimum standard of infrastructure should be provided to the voluntary sector, and to consider how the NHS as well as local authorities could help in relation to estates from which the sector could deliver its work.
3.06	Sir Norman Lamb welcomed the priority and commitment given to the VCSE in the charter and recruitment of a Director post to co-ordinate collaboration and partnerships. The links to the strategic priorities were clear but the challenge was to translate the principles into real change and take into account the tension between system and Place. The sector had the potential to reach areas of the community unreachable by the statutory sector.
3.07	Andrew Bland conveyed a comment from Cllr Colin Smith which explained that Bromley Council already commissioned most its services from VCSE organisations and could commit to continue this approach, but would not be in a position to increase funding.
3.08	Andrew Bland presented give key actions that the ICB was proposing to support the development of the VCSE Charter in 2024/25 supported by a modest additional funding invested in place to help facilitate wider challenge. These included ensuring VCSE representation on appropriate committees and remuneration to support this contribution, the creation of an enhanced infrastructure fund for VCSE organisations to support grassroots organisations, increasing funding to grassroots organisations

	through an enhanced grants fund, a review of void spaces across the NHS with potential for use by the VCSE, and a collaborative review of the procurement policy to ensure it worked for VCSE organisations.
3.09	Catherine Mbema welcomed the proposal and suggested that appropriate support and training may also be useful to enable VCSE representatives to contribute to system forums.
3.10	Folake Segun welcomed the commitments to support the VCSE as a good way of building transparency and trust in communities generally.
3.11	Cllr Jim Dickson conveyed a comment from Cllr Scott McDonald that local authorities were currently spending more on VCSE assets than the NHS, however significant funding challenges may affect local authorities' ability to continue investment. Richard Douglas emphasised that the charter was intended to encourage additional support for the sector rather than create substitutes for existing investment.
3.12	Cllr Keiron Williams welcomed the focus on grass roots organisations which often were the best at reaching communities with the poorest health and care outcomes.
3.13	The Integrated Care Partnership **agreed** the charter asking for a change to reflect that funding increases were in aggregate across the system.
4	**Integrated Care Strategy**
1.01	Andrew Bland introduced the item which aimed to summarise the journey to develop the strategy, make recommendations on actions and propositions of how to progress them including the financial aspect.
1.02	The ICB had agreed to ring-fence funds to support working differently, and since the agreement of strategic priorities had conducted a process to identify how to narrow and focus efforts to delivery the strategy which had led to the recommendations presented. The proposals did pretend to address every challenge in the system, but tried to focus on existing excellence, and initiatives shown to work that could be scaled up. The strategy acknowledged both differences between each Place as well as the opportunity to make a difference by collaborating, and imperatives shared by all boroughs such as the need to support disadvantaged groups and elderly populations.
1.03	Maria Higson explained that proposals for action in relation to the five strategic priorities aimed to build on and accelerate work already underway. On prevention, evidence and experience particularly through Covid-19 pandemic had demonstrated that building trusting relationships was key to improving prevention, and in each borough efforts were under way to build these links with local people. A collaborative of leaders was proposed so share the best practice in this area.
1.04	There were examples of VCSE organisations across the system providing sometimes lifesaving support to families, however limited resources and staff raised concerns about continuity of support and access. It was proposed to prioritise the development of new or extended services that utilised generalist caseworkers to provide holistic support for families, and share expertise across south east London.
1.05	The complexity of challenges facing Children and Young People's services was recognised nationally, however in south east London a range of support was being provided to increase resilience and support wellbeing amongst young people. The proposed approach was to focus this support on children in the most marginalised communities furthest from the services they needed. Community connector roles could bring together residents, local organisations, NHS, councils, schools, the VCSE and other partners to co-design initiatives, establishing a collaborative to share learning.
1.06	Throughout engagement in relation to Adult Mental Health, people had consistently emphasised the need to develop trusted relationships between people and communities. Where early intervention was not successful, adults frequently presented at emergency services having reached a mental health crisis point, however capacity for early intervention in primary care was limited. The proposal

	was to make funding available, via microgrants to VCSE organisations, to develop hyper-local interventions for adults with common mental health challenges in the neighbourhoods furthest from current services.
1.07	The final priority to ensure that health and care for an aging population with increasingly complex needs was more joined-up and person-centric, would be addressed by a focus on neighbourhood teams would share best practice, evaluate outcomes, as well as bring in expertise from outside the system where appropriate.
1.08	Norman Lamb welcomed the work on the priorities, and agreed to the need to share best practice, citing Surrey Square school as an example of good work to address determinants of ill health. The biggest challenge was that the work would be 'under-powered'; supporting good, but relatively peripheral projects not at the scale required to achieve a fundamental shift of resources from acute reactive care to preventing ill-health in the first place. Procuring additional bed-based support for example to address immediate challenges risked limiting the work which could deliver change and build resilience for the future.
1.09	Cllr Jim Dickson recalled the challenge set by Sir Michael Marmot at the partnerships' first meeting to address the wider determinants of health. The Adult Mental Health priority focused on what residents had said they needed most: access to services when they were needed, and support in crisis. The work now needed to become business as usual across the ICS.
1.10	Michael Nutt reflected that all of the ambitions set out depended on digital transformation for their delivery. In the context achieving the aims by efficiently using limited resources, connected systems and data were needed to ensure the right staff and information were available at the right place and time.
1.11	Cllr Keiron Williams described the initiatives as a step along the way with the timeline for future work and progress to scale the work remaining an important question.
1.12	Richard Douglas noted that the proposals did not represent all the work being done. Instead, interventions in relation to each priority which were thought to be most capable of making an important difference and being additional to the work going on at place.
1.13	Andrew Bland acknowledged that the initiatives by themselves risked being underpowered, but that there was an opportunity to consider how successful work could be scaled, and noted the commitment in the Medium Term Financial Strategy to protect a growing proportion of spend for work in this area.
1.14	Tal Rosenzweig described a golden thread through the strategy of building trust, utilising VCSE organisations and directing money towards prevention and health creation. It was important to note that work in this area may not deliver immediately but commitments should still be made for the future.
1.15	The Integrated Care Partnership **supported** the recommendations for cross system action to deliver the priorities.
5	**Questions from members of the public.**
5.01	Cllr Kieron Williams noted that answers had been provided in writing to the questions asked in advance of the meeting and published on the ICBs website and asked if any members of the public observing the meeting wished to follow up on aspects of those questions.
5.02	*Question: A response to a question about the move of the Camberwell Dialysis Unit run by Diaverum UK to a new unit in Brixton had referenced regular conversations with staff affected by the move.* *A follow-up question was asked about whether these conversations with staff had included discussion of pay, the questioner expressing concern that staff working for outsourced services were often not paid at Agenda for Change rates.*

5.03	Andrew Bland confirmed that the service was run by Guy's & St Thomas NHS Trust and King's College Hospital NHS Trust who could be contacted for a response.
5.04	*Question: A query had been raised in December 2022 around the monitoring of the south east London Pathology contract and the availability of monitoring data. Responses indicated that the contract was being monitored but the data was not being made public, and that the data was exempt from release under the Freedom of Information act under Section 43 on the basis of commercial in confidence.* *The questioner reiterated a follow up question which had been asked but not answered which had acknowledged that some financial information could be argued to be exempt under section 43, but data about the monitoring of quality of the service ought not to be exempt for this reason. The £2.25bn contract was one of south east London's largest and affected many clinical procedures and GP visits, and there was some feedback from those working in health and care to Keep our NHS Public that the service was not effective. This was of particular concern given following reports that the service would be extended to cover Royal Brompton and Harefield following the merger with Guys and St Thomas's NHS FT.*
5.05	Andrew Bland noted that the south east London ICB commissioned pathology services from the acute trusts within south east London (*Guys and St Thomas's NHS FT, Kings College NHS FT, and Lewisham and Greenwich NHS Trust)* who had let the contract for the pathology network. The CQC inspected all aspects of care at these trusts as regarded quality, and Quality surveillance groups at the ICB discussed any aspects of quality which had come to light as a concern.
5.06	*Commenting on the responses, Members of the public commented that the original procurement board had been set up by Our Healthier South East London – the ICS should not distance itself from the contract. The FOI response had not provided details of those responsible for letting the contract, which was not in line with the transparency expected.*
5.07	Norman Lamb emphasised the importance of the principle of transparency where possible. Richard Douglas noted that original response to the FOIs could be reviewed.
5.08	*Question: The partnership were asked about a matter which had not been addressed in the strategic priorities work outlined. Black and African residents currently using or who would in the future need daycare and residential provision often received services which did not take into account their needs in terms of haircare, skincare and the food offer provided to residents.*
5.09	Cllr Kieron Williams noted that the strategies focused on prevention of people falling into ill health. Andrew Bland added that the strategy did not specifically address this issue as it deliberately focused on a small number of issues. There were however health and wellbeing strategies and the work of local boroughs.
5.10	*Question: The partnership were asked to note formally that a request had been made by the KINARAA community interest company for the board to visit Lewisham, and that following that request a visit had been made by the chair and CEO of the ICB.* *The questioner asked what the ICS would do to help those on low incomes particularly who were also from the Black and minority ethnic communities to access digital healthcare. Digital was a great way to access care for many people, but currently some did not earn enough to access these services, particularly in Lewisham with one of the lowest levels of income in London.*
5.11	Andrew Bland noted that the ICBs digital strategy included discussion of how to reduce inequality of access to digital services. The strategy was currently being updated but could be brought to a future meeting.

South East London
Integrated Care System

Matters arising
From record of previous meetings

At the last meeting, the partnership heard an update on **Elective care**.

- Partners expressed concerns about the long waits and their effect on residents, asking the ICB Board to consider their concerns. The ICB board has since met in 15 November 2023 and 31 January 2024 and papers are available here. At both meetings the pressures facing the system were updated on and risks considered, and in the November meeting some of the work using data to identify and support those most affected was presented.
- Partners expressed a wish for a similar update on the pressures faced in social care, and a portion of the February meeting is devoted to this.

The partnership approved a **VCSE charter** with clarified wording on financial contribution.

- Some next steps were promised by the team and they are reproduced below.
    - Since the last meeting plans have been in development to implement the charter, focusing on the commitments made by the ICB first.
    - Engagement on implementing the Charter is continuing with a wide range of system partners from the SEL VCSE strategic alliance, Local care partnerships, and NHS Providers. The team are reaching out to remaining partners to further explore implementation plans from their perspective.
    - The process of identifying individuals to lead each priority area has started drawing from across the partnership and ICB.
    - The key structures and fora necessary to progress the plans have been identified both across London, in each Place, and in forums and spaces led by providers.

Actions to deliver the Integrated Care Strategy were proposed to members

- The Strategy returns to February meeting following the input of members on proposals for action presented to the last meeting.
- The underpinning importance of Digital and data to deliver the strategic aims of the partnership was noted, and it was agreed to consider this as the strategy develops.

Questions from the public were taken

- The Partnership were asked a question about the move of the Camberwell Dialysis Unit run by Diaverum UK and discussions with staff. It was noted that the Partnership was not able to answer directly as the move was managed by the NHS trusts involved in delivering the service.
- The Partnership were asked some questions about the NHS Pathology contract let by NHS trusts in South east London. A response provided to a member of the public from the ICB is appended below, and responses to follow questions provided below.
    - *The ICB's Chief Nurse has been in direct contact with the CQC who have advised that they are not aware that pathology services have been inspected specifically in south east London but that they will be inspecting pathology services under their new methodology, in the future.*

- *The Executive directors responsible for pathology in KCH and GSTT are Julie Lowe, Denmark Hill Site Chief Executive and Dr Simon Steddon, Chief Medical Officer respectively.*
- *The ICP is a meeting in public. The public are invited to submit questions in advance or attend meetings in person. It is not logistically possible to recognise on-line attendees due to the infrastructure and resources available to the ICB. Papers are published 5 working days (7 calendar days) before the meeting and the public have 3 working days (5 calendar days) to raise questions in advance (the opportunity closes at 10.00am on the Monday before the meeting). Questions are answered ahead of the meeting and published on the website the day before the meeting is held.*
- *Questions accepted at an ICP or ICB Board meeting should be in relation to the agenda items, at that meeting, therefore it is sensible to continue to have public question time at the end of the agenda once the papers have been discussed.*

- The partnership were reminded of the need to provide a culturally appropriate care and food offer for those receiving day care or residential care south east London.
  The CQC who regulate care homes have recognised culturally appropriate care (also known as culturally competent care), as relevant to regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 Person centred care, Regulation 10 Dignity and respect and Regulation 11 Need for consent. The ICB and local authorities work with care settings to help raise the standard of care provided to users.
- The risk of digital exclusion was raised. The ICS is currently refreshing its digital strategy and the need to address digital exclusion will be reflected in this work. The ICB received an item on Digital and data at its January board and has reflected the need to support this agenda in its staffing structure. Partnerships in Places will also be able to lead local work designed to help all residents benefit from digital tools.

South East London Integrated Care System

NHS South East London

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Sent by email
[redacted]

8 November 2023

Dear [redacted]

Following your question at the recent Integrated Care Partnership meeting I undertook to look personally at your various questions and FOI requests relating to the Synnovis contracts. These were focussed on the issues of quality monitoring of the contract, GP complaints and placing quality information in the public domain.

I am sorry this has taken longer than I hoped but I wanted to make sure I had seen all the relevant papers. I have now personally reviewed all the requests/questions and the responses. From this review I am satisfied that:

a) there are robust quality monitoring processes in place to ensure that the ICB and its partners are alerted promptly to any quality and performance issues on this contract as on others;

b) your FOI requests and questions have been dealt with appropriately, recognising that there was a misunderstanding and delay in response to your email question to the ICB meeting made on 15 February 2023;

and

c) we have been advised that the detailed quality and financial information you requested could not be provided as it was exempt under Section 43 of the Freedom of Information Act.

I suspect this is not the answer you may have hoped for but nonetheless I do hope it is helpful. I would also like to remind you that should you remain dissatisfied after all reasonable efforts have been completed, and would like to take your complaint further, you can contact the Information Commissioners Office (ICO).

All the best

Richard Douglas
Chair, South East London Integrated Care Board

South East London Integrated Care System

Integrated Care Partnership

Title:	**Adult Social Care – system pressures**
Meeting Date:	8th February 2024
Lead / Contact:	Stuart Rowbotham. Director of Adult Social Care and Health, Lonodn Borough of Bexley / ICB Place Based Executive for Bexley. Supported by Nick Davies. Director of Adult Social Care. Royal Borough of Greenwich Peter Turner. Director of Finance. London Borough of Bromley
Authors / Contributors	Ian Buchan, Programme Lead ICS DASS Group

Purpose of paper:	To update the ICP of the current pressures in local authorities and particularly in adult social care departments in South East London. To explore these challenges as a partnership and how the partnership might respond in a collaborative way to secure solutions which support the whole system.	**Update / Information**	
		Discussion	X
		Approval	
Brief summary of the paper	Local authorities have to by law set and maintain a balanced budget but currently they have a number of challenges which make this a complex and very challenging task; This paper sets out the current financial position of the South East London authorities and details where some of those pressures originate from. 1. Local authorities are managing a range of in year cost pressures which will feed into ongoing budgetary pressure in 2024/25 and beyond. 2. The budgetary pressures in Adult Social Care stem from, a. The general increase in the numbers of people adult social care is supporting. b. increased acuity of people accessing support. c. responding to the increased needs and acuity of those being discharged from hospital and how this feeds through into longer term costs for the local authorities. d. Workforce challenges in the recruitment, retention of staff and the use of agency staff when this is not possible, particularly in relation to qualitied social workers and occupational therapist. 3. Cost pressures for local authorities in meeting its responsibilities under housing legislation and the associated costs of a higher use of temporary accommodation in meeting these responsibilities.		

	4. Cost pressures from the increased demand in Children Social Care, particularly as they respond more positively to the support needed by children and young people who are neurodivergent.
Recommendation:	**The Partnership is asked to:** I. Consider the opportunities to work across boroughs and accelerate the Integrated Neighbourhood Based Care (Fuller) to improve health and reduce admission, coordinating this with work proposed by the Accelerating Social Care Reform Fund Expressions of Interest, so we can work in a more joined up way across our local authorities and 'Places' to realise the benefits and efficiency this would bring. I. Identify further opportunities for integration and workforce development. II. Explore how we might collectively increase access to therapies for people in the community to help increase levels of independence and reduce the need for admission to a care home or increased long term care provision. III. Work together to better understand the reduction in Standard Continuing Health Care eligibility rates for SE London, so residents are getting the right level and quality of care to meet their needs and not having to pay for care when it should be free at the point of delivery.

South East London Integrated Care Partnership

Adult Social Care – Context and system pressures

1. Introduction

Local authorities have a duty to set and maintain a balanced budget and are not allowed to carry forward a deficit. Therefore, with the current demands and no long term new money into the system, they are having to carefully consider how they manage and respond to the range of issues identified below. As well as identifying opportunities that working as system partners might bring for those citizens we support, while addressing issues for the system as a whole.

2. National policy context

The Government's adult social care reform white paper, 'People at the Heart of Care' set out a 10-year vision for care and support in England based around three key objectives:

1. People have choice, control, and support to live happier, healthier and independent lives
2. People can access outstanding quality and tailored care and support delivered by a skilled and valued workforce in an integrated health, care, and community system.
3. People find adult social care fair and accessible, fees are transparent, information and advice are user-friendly, and no one is subject to unpredictable and unlimited care costs.

The Care Act 2014, The Mental Capacity Act 2005, The Mental Health Amendment Act 2007, along with Equality and Human Rights Legislation set out the basis for the work local adult social care departments do.

These acts of parliament set out the role local authorities should take in their localities and defines a range of duties and responsibilities they have in supporting their citizens. The Care Quality Commission (CQC) will 'assure' (or might be better described as Inspect) local authorities against these duties and responsibilities in the coming years as the CQC have commenced their assurance process for Adult Social Care, which so far is focusing in London on local authorities in the north west sub region. Pilots of assurance of ICS's have begun and will be rolled out more widely in the coming year.

3. Local Authority Context

Social care across children's and adults services makes up the majority of Council budgets and will need to find savings in order to achieve a legally balanced budget. Adult social care funding has not kept pace with changing demography, increase in demand for services and NHS increases, so we are starting from a large deficit position. Where we have had welcomed additional funding, it has been used in the areas directed such as hospital discharge or been to address the challenges Children's Services are facing too.

Local authorities report three areas where they see ongoing cost pressures generally,

1. Children and Young People social care, particularly in responding to the needs of young people who are neurodivergent as we respond to the historically poorly understood group.

2. The challenge of Homelessness and the increased demand for temporary accommodation and associated costs of accommodation in London.

3. Adult Social Care (ASC) – the areas ASC see pressures are detailed below.

    a. Placement and providers cost increases – while inflation is starting to come down, the National Living Wage will increase by 9.8% in April 2024, and the Lonodn Living Wage by 10.04%, as staff wages make up between 60-70% of the unit price of care services, be that in a care home or with a home care provider, this will be a significant cost pressure for local authorities to manage.

    b. The cost and availability of care home placements have been an issue for some local authorities over the last year. With Southwark Council only this week working to buy a care home, to maintain capacity in the local market to meet their needs. Other local authorities have had to pay higher fee rates to secure beds they needed. This can also cause delays in a small number of hospital discharges where the person's needs are very complex and few care homes would be able to meet these needs. Resulting in placements being made at a higher rate than a local authority would usually pay and often outside of the local area.

    c. Staff vacancy levels in some boroughs continue to impact us, despite work done to address this challenge. It impacts our ability to respond in a timely way to requests of support and meet all of our statutory responsibilities in the timescales we would want. Where we are able to recruit agency staff the costs are higher and does not always fill all our vacancies.

    d. Transitions (young people moving between Childrens and Adult Social Care responsibilities as they get to 18 years old) cases on average have a higher care cost than most individuals receiving support from an Adult Social Care Departments and therefore can be a cost pressure given their complexity and needs. This and the increased demand for support from working age adults has been the driver of at least one local authority's significant overspend and only requires a small number of individuals with high needs to put the budget under significant pressure.

    e. The reduction in the numbers of people in SE London receiving Standard Continuing Health Care since 2017, also adds a potential unseen demand on social care budgets and a reduction in the rights of individuals (some of whom may have to sell their homes or use savings to pay for care). According to NHS England CHC Data, for the SEL ICS, Standard CHC , cases per 50,000 of population reduced from 49.98 people in 2017/18 Q1, to 33.96 people per 50,000 in 2023/24 Q2. Reductions have been noted across other parts of London, but mostly at a lower level than the reduction in SEL.

    f. While the acuity of people being referred to ASC has increased both from the community and from hospital, a number of local authorities are reporting an increase in the overall number of people they are supporting, on average ASC is seeing a 17% increase in England.

We are awaiting the outcome of the Accelerating Adult Social Care Reform Fund, Expressions of Interest, the six local authorities made with support from health colleagues, for the following two projects,

a. Provide services that reach out to, and involve, unpaid carers through the discharge process.
b. To join up data across health and care in new ways to explore which interventions are most impactful in being able to prevent increases in the need for support, avoid admission and prevent situations where people are unable to remain independent at home.

These opportunities along with other work going on across the ICS are a good foundation to work together on issues which affect us all and improve outcomes for our citizens.

4. Hospital Discharge

Hospital discharge work is a key area for local Adult Social Care Departments, given the increased acuity of people on discharge from hospital which has been well set out previously, we see this as a driver for higher long term costs which local authorities have to absorb.

This higher acuity and the nature of earlier discharge passes a number of costs on to local authorities, as people don't access the same level of therapy support in hospitals as they would have previously, and we have not, due to recruitment and financial challenges ensured there is adequate therapy provision in the community to support people in a timely way back to previous levels of independence.

Adult Social Care see that they have good and affective working relationships with acute colleagues and manage the flow of people out of hospital efficiently but acknowledge that in a few complex cases, discharge planning and securing the right service to support the individual on discharge is challenging and can take some time. We are working with acute colleagues to identify these individual earlier in the process so we can start working with the person and their families to find the appropriate support to facilitate discharge.

The negative narrative, that social care causes significant delays in discharging people from hospital does not set out the full range of reasons for people's length of stay in hospital. We need to acknowledge the positive relationships and work we do to facilitate hospital discharges and work with our acute colleagues to address all issues that can contribute to the more effective use of hospital beds and ensure that people get the care and support they need in the right setting and only remain there when it is needed.

'Finding a Way Home' Report By Newton Europe (an experienced consultancy) - (https://www.countycouncilsnetwork.org.uk/new-report-sets-out-how-hospital-admissions-can-be-avoided-and-how-patient-flow-can-be-improved-ahead-of-busy-winter-period/) recommends refocusing on delays contributing to length of stay within hospitals – which they found to be 47% were waiting for diagnostic tests, and 40% were waiting for decisions from medical staff.

Working together earlier and addressing the issues we both have in manging the flow of people into and out of hospital would improve the efficiency of the system and enable people to have shorter stays in hospital which should reduce the level of deconditioning people experience, which in turn can decrease their need for ASC support on discharge.

5. Current Budgetary Position (where known)

Local authorities across south east London are all facing significant in year overspends with adult social care making a significant contribution to the overall overspend position. In moving forward these authorities are all facing a deteriorating financial position with significant budget gaps being forecast

requiring savings to be delivered. Even after recent Government announcements for funding this does not cover the scale of growth/cost pressures facing these Councils, which will contribute towards a worsening financial position. There may be a reliance on NHS financial support reflected in some of these projections, where they have been agreed locally which could result in service reductions if funding cannot be realised. Adult social care represents a large proportion of their spend and clearly cannot be immune from the need to find financial savings. Any withdrawal /or cease continuation of funding from health will have an impact on service delivery resulting in potential greater cost pressure on NHS services.

The new money announced earlier this week, which will be very welcomed has been allowed for in the general fund figures below and will be subject to further internal agreements about how it is used.

Some of the financial projections identified below for 2023/24 are based on Q2 financial monitoring rather than Q3 (Bexley and Southwark have provided Q3) and any updates available will be provided at the meeting.

The table below sets out the current financial position of each local authority.

Local authority	In year pressures	2024/25	2025/26	2026/27
Bexley	£8.6 general fund overspend. £2.75m ASC and Public Health	£29.7m gap	£38.4m gap	£43.35m gap
Bromley	£1.1m total general fund overspend. £1.5m for ASC		£16.6m gap	£34.3m gap
Greenwich	£32.8m total general fund overspend. £7.7m for ASC			
Lambeth	£29.8m total general fund overspend.£5.2m for ASC			
Lewisham	£28.6m total general fund overspend. £3.4m for ASC			
Southwark	£3.4m General Fund overspend. £0.5m ASC	£20.8m gap	£22.9m gap	£14.1m gap

6. Areas of opportunity to explore.

There are four areas where, as a system by working together at scale (across boroughs) would assist us to address costs, improve outcomes for local citizens and enable people to access services they have a right to.

I. Rather than focus on hospital discharge we need to look at a stronger preventative offer, using AI to enhance this and targeting those most at risk of an admission, enabling a smarter way of identifying those who would benefit from support earlier to reduce the long term needs and improve their independence. A pilot on this has been undertaken in Norfolk to help reduce the risk of falls. Although only using council data to date, NHS partners have recognised the opportunity to develop this further. https://www.norfolk.gov.uk/news/2023/09/computer-data-helps-target-support-to-those-at-risk-of-a-fall

There are opportunities to work across boroughs and accelerate the Integrated Neighbourhood Based Care (Fuller) to improve health and reduce admissions. Working in a more joined up way across our local authorities and 'Places' would give us these benefits and be efficient.

II. Identify further opportunities for integration and workforce development.

III. Explore how we might collectively increase access to therapies for people in the community to help increase levels of independence and reduce the need for admission to a care home or increased long term care provision.

IV. Work together to better understand the reduction in Standard Continuing Health Care eligibility rates for SE London, so residents are getting the right level and quality of care to meet their needs and not having to pay for care when it should be free at the point of delivery.

Integrated Care Partnership

Item 3
Enclosure C

Title:	**Implementing our South East London Integrated Care Strategy**
Meeting Date:	8 February 2024
Authors:	Ben Collins, Director of ICS System Development
Executive Leads:	Toby Garrood (ICB Medical director)

Purpose of paper:	To seek the IC Partnership's support for a proposed approach and next steps to deliver our integrated care strategy. If the Partnership supports these proposals, the Integrated Care Board will consider how to progress them as part of its planning process for 2024/25.	Update / Information	X
		Discussion	X
		Decision	X
Summary of main points:	- In our strategy publication of February 2023, we committed to action across SEL to address five priorities: prevention, early years, children's and adults' mental health and primary care and long-term conditions. - Following discussion with the Partnership in October 2023, this paper sets out more detail on proposed interventions to help deliver our strategic priorities. - Specifically, we are proposing a focus on relationship-based approaches to prevention such as the community health worker model, intensive social support for mums and families with high vulnerabilities, a family zone model to support children in disadvantaged neighbourhoods, VCSE-led and social approaches to supporting adults with mental health challenges. We are also proposing to support development and learning, and define our approach to implementing integrated, team-based primary and community care. - We propose to adopt a proof-of-concept approach to these interventions, with piloting to test their application in a local setting and develop cross-system learning as well as building further evidence on their impact for health and wellbeing. We will also use the pilots to develop an agreed approach to rolling out and mainstreaming successful initiatives.		

	- The Annex provides more detailed project initiation documents the proposed interventions for each of our strategic priorities.
Recommendation:	• We are seeking the Partnership's support for these proposals so that they can be considered as part of the NHS planning round for 2024/25. • We would welcome any reflections or advice from Partnership Members on how to make sure these investments are made as effectively as possible.

Implementing South East London's Integrated Care Strategy
Paper for SEL Integrated Care Partnership – 8 February 2024

1. Introduction

1.1. In early 2023, following engagement across our system, we established five strategic priorities for south east London covering prevention, early years, children's and young people's mental health, adults' mental health and primary care and long-term conditions. We selected these areas because of the size of the opportunity to improve health and care and the opportunity to make faster progress through collaboration.

1.2. In the following months, we clarified the focus of these strategic priorities and defined measurable ambitions for improving care. In its meeting of October 2023, the Integrated Care Partnership agreed our proposals to focus additional attention and funding on a set of specific strategic interventions to help deliver our priorities, alongside many other strands of work across our system. These interventions reflect our assessment of the challenges we face in each of these areas and the evidence on what works in our system, nationally and internationally.

1.3. As agreed with the Partnership in October, this paper now sets out more detail on these proposed interventions to help deliver our strategic priorities. It describes at a high level the nature of the projects and the types of impact we would expect them to deliver. Each set of projects would be for an initial period of two years followed by review.

1.4. If the Partnership supports these proposals, the Integrated Care Board will consider funding options as part of its planning process for 2024/25. We propose to adopt a proof-of-concept approach to these interventions, with piloting to test their application in a local setting and develop cross-system learning as well as building further evidence on their impact for health and wellbeing. We will also use the pilots to develop an agreed approach to rolling out and mainstreaming successful initiatives. This would include developing a funding approach that reviews and reorients existing investment where needed, recognising the constraints that will exist on future funding growth.

Figure 1: Agreed priorities and ambitions and proposed interventions.

Priority	Challenge	Ambition	Proposed intervention
Prevention and wellbeing	Delivering primary prevention effectively to our most disadvantaged communities	Close the gap in uptake of these services for people from disadvantaged groups	Community and relationship-based approaches to prevention which seek to establish sustained relationships with people from under-served communities and provide support for a wide range of health and wellbeing challenges
Early years	Supporting mums, babies and families with high vulnerabilities effectively in first 1001 days	Safer births, with fewer complications for families with high vulnerabilities, improvement on key measures of good start in life.	Intensive, generalist approaches to supporting parents, babies and families with high vulnerabilities, which support families to tackle major challenges while connecting them into support networks and local resources
Children's and young people's mental health	Supporting children's emotional wellbeing and common mental health challenges in disadvantaged neighbourhoods	Fewer children developing emotional and mental health problems in disadvantaged neighbourhoods, higher school attendance.	Partnerships between local communities and VCSE organisations, schools and public services to develop 'Family Zones' to support children and families' wellbeing in disadvantaged neighbourhoods
Adults' mental health	Ensuring access to rapid, trusted and effective early support for common mental health and social challenges.	Fewer people from disadvantaged groups entering crisis or developing more severe mental health problems.	VCSE and peer-led, socially-oriented support for adults with common mental health challenges in disadvantaged neighbourhoods
Primary care and people with long-term conditions	Delivering proactive, joined up support for long term conditions and people with complex health and social needs.	More people with LTCs and social challenges who report a positive experience of care, live independently and enjoy good lives.	Developing 'test case' models of integrated neighbourhood teams in disadvantaged neighbourhoods so that we can codify effective service designs and approaches to transitioning to a team-based model of primary, community and social care

2. Overall approach across our strategic priorities

2.1. For each of our strategic priorities, we identified a specific ambition to improve care and outcomes, focusing on our most disadvantaged groups. We assessed the underlying reasons why services were struggling to meet people's needs effectively. We then looked for evidence and examples of the types of interventions that are having the greatest impact for these groups.

2.2. Across our priorities, there was a set of consistent themes relating to how we are currently delivering care. For example, the lack of trust and understanding between disadvantaged communities and statutory services is a barrier to effective delivery of preventative care, early years support and mental health care. In each area, there was an over-reliance on medical interventions, and a lack of social support. In each area, there were opportunities to bring together partners and services and deliver more holistic care for people with interrelated health and social needs.

2.3. Given these common problems, there are also common features to the solutions we identified. For example, in each area, we are advocating the development of services that are more specifically tailored to the needs of disadvantaged communities and more explicitly built around defined physical neighbourhoods. In each case, we are advocating generalist models of health and social support. In each case, there are opportunities to build stronger partnership working across health, local authority services and the VCSE sector.

2.4. Perhaps the most important theme is the role of the VCSE, including hyper-local community organisations, in developing and delivering these services. This is specifically because of the VCSE's ability to build strong trusting relationships with our most disadvantaged groups, local VCSE organisations' understanding of local neighbourhoods and their ability to connect local assets, and their experience in delivering holistic support combining health and social support.

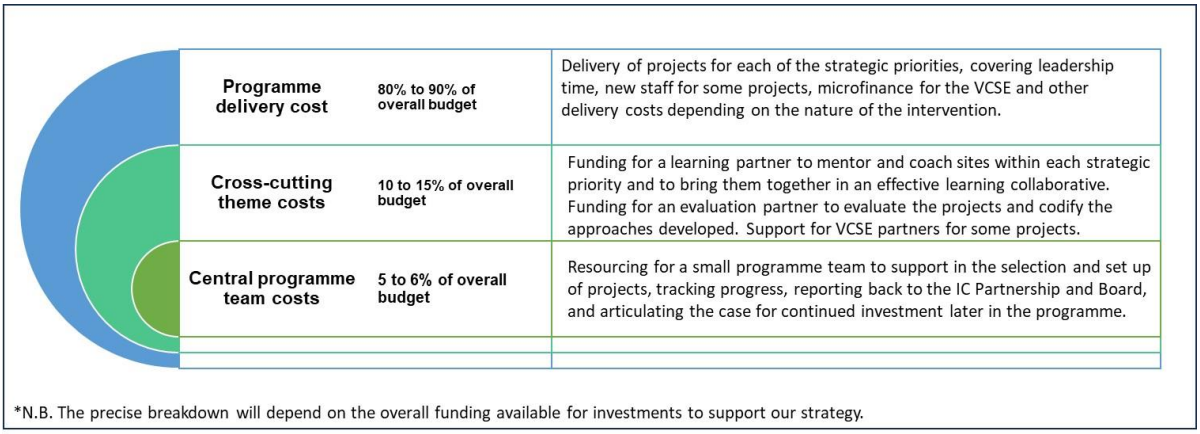
Figure 2: Overall approach across our strategic priorities

Focus	…. On our most disadvantaged people and communities
Tailored approaches	…. Designed specifically to be effective for disadvantaged communities, rather than a one size fits all model.
Small neighbourhoods	…. As the best starting point for connecting with our communities and developing support around them.
Whole-Person	… With generalist team-based support for health and social challenges, not separate services for each problem.
Assets-based	…. Connecting and developing assets in neighbourhoods and harnessing communities and service users

3. Use of available resources

3.1. As we discussed in 2023, our objectives include allocating resources and attention to a set of interventions which should help us to accelerate progress in meeting our strategic objectives while at the same time developing our approach to working together and sharing learning across our system on service change. With this in mind, our plan would be to allocate available funding to three areas: the vast majority would be allocated directly to our Local Care Partnerships and health and care organisations to deliver projects in support of our strategy. However, we would retain a small proportion of the budget to fund a central team to coordinate the programme and a small proportion for sharing learning and evaluation.

Figure 2: Illustrative breakdown of annual funding



3.2. Following our meeting in October, we have developed costings for the proposed interventions or projects for each of our strategic priorities. For most of the priorities, we believe we could deliver an effective pathfinder project for between £130,000 and £200,000 per year (depending on the intervention), which would have a significant impact for a small cohort or neighbourhood, and would help build the evidence base for spreading the approach. For primary care, the costs are slightly lower, because the focus would be on coaching and change management support rather than hiring any new staff.

3.3. This means that we can adapt the programme to fit different funding envelopes, with the number of projects for each priority reflecting overall funding. We will need to consider the optimal implementation approach when we have a clearer understanding of available resources and the capacity within our system to support these types of service development projects. If needed, one option would be for each borough to focus on implementing projects under one or two of our strategic priorities rather than all of them, with a spread of projects across each of our local care partnerships.

*Figure 3: Overview of proposed projects**

Strategic priority	Proposed projects	Illustrative potential costs / investments*	Potential reach	Additional Notes
Prevention	Community health workers to support health prevention in disadvantaged neighbourhoods	One coordinator and four community health workers per project	Each team / project capable of reaching and building sustained relationships with c. 400 households or 1000 people in a defined neighbourhood.	Estimates based on Westminster Council's community health worker scheme for disadvantaged neighbourhoods
Early Years	Intensive, generalist support for mums and families with high vulnerabilities over first 1001 days of life	One project team comprising part time senior leadership, clinical supervisor and lead, full and part time key worker and therapist.	Each team / project capable of supporting c. 80 to 100 mums and families with high vulnerabilities per year.	Estimates based on high performing local service services and informed by Birth Companions' pilots.
Children and Young People's Mental health	Development of family zones around schools in disadvantaged neighbourhoods, focused on developing the school and neighbourhood to protect children's mental health and wellbeing	One small team comprising zone manager, family connector, and other community staff and microfinance for community initiatives	Each project capable of providing support for around 1000 children and their families within the main catchment area of a primary school	Estimates based on Big Education's Old Kent Road family zone, supported by Impact on Urban Health.
Adult mental health	Development of VCSE services offering socially-oriented, non-medical support for adults with common mental health challenges	Part time senior oversight, part or full-time key workers or peer support workers, rental and other core costs	Each project capable of providing support for around 100 to 150 adults per year, depending on the precise model.	Estimates based on Mosaic Clubhouse's service for supporting adults with mental health challenge sin Brixton.
Integrated Neighbour-hood teams	Development of models of integrated, team-based primary / community care in disadvantaged neighbourhoods	Coaching and change management support inc. for collaboration with local community, service design, implementing effective teamworking, applying QI methods, developing local VCSE.	Each project with potential to improve care for catchment areas of 30,00 to 50,000 people depending on precise INT model	N.B. The funding for these projects would be used to support the development and implementation of new care models. It is not intended to cover staff costs.

4. Prevention

4.1. For prevention, we have committed to improving primary prevention for our most disadvantaged communities, so that we close the gap in uptake of these services and improve health and life expectancy for people in disadvantaged groups. Our research highlighted lack of sustained trusting relationships as the most important factor in poor uptake of common prevention services in disadvantaged communities.

4.2. In light of this research, we proposed to make additional funding available to accelerate the development of relationship-based approaches to prevention in defined neighbourhoods. This would build on VCSE-led approaches in south east London and the community health worker model being developed in ICSs across England.

4.3. Following discussions with local sites and sites across England, we are proposing that funding is specifically focused on projects that hire local people as health workers, focus on a specific disadvantaged neighbourhood, engage on a wide range of health and wellbeing issues and work in close partnership with the integrated neighbourhood team and GP practices in the neighbourhood, Local Authority early help services and local VCSE organisations. A single project along the lines we outline should be able to improve take up of preventative services, as well as addressing many other health and social issues, for 400 households or 1000 people in a defined disadvantaged neighbourhood.

4.4. There is a strong evidence base on the effectiveness of this model for disadvantaged communities. In Westminster, households that received community health worker visits were significantly more likely to have received the screenings, health checks and immunisations they were eligible for than households that did not receive visits. Internationally, the approach has been shown to lead to healthier lifestyles, lower rates of preventable illness, more equitable access to health services and lower hospital bed days.

5. Early years

5.1. For early years, we have committed to improving the support for parents, babies and families with high vulnerabilities in the first 1001 days, so we ensure safer births and improvement on key measures of a good start in life. Our research highlighted the need for more intensive support for families with high vulnerabilities and more holistic support covering health and social needs. It also highlighted the role of the VCSE in establishing sustained trusting relationships with families and overcoming deep distrust of statutory services within many disadvantaged groups.

5.2. In light of this, we have proposed to make additional funding available for the development of new or extended services for parents and families with high vulnerabilities, drawing on learning from successful approaches in south east London, research and pilots by national charities, and Changing Futures initiatives across England. A single project along the lines we outline would be able to provide intensive support for 80 to 100 mums and families with the highest need every year.

5.3. Following discussions with national charities and local services, we are proposing that funding is specifically focused on services which develop experienced case workers, deliver a relationship-based approach to care, provide holistic support for health and social challenges, active support for benefits, housing and other social welfare issues, and approaches that harness the resources of mums and families and bring them together in support networks. There are opportunities for these services to work in close partnership with integrated neighbourhood teams and family hubs. Again, we are

drawing on a detailed evidence base for this approach, including research by national charities for vulnerable mums and families.

6. Children and young people's mental health

6.1. For children and young people's mental health, we have committed to improving support for children's mental health and emotional wellbeing in disadvantaged neighbourhoods, so that fewer children in these neighbourhoods develop mental health problems and children achieve have higher educational attainment. Our research highlighted the complexities of protecting children's wellbeing in highly disadvantaged neighbourhoods and the need to address a wide range of issues relating to poverty, housing, immigration, relationships, school environments, health and many other problems. While there are no simple solutions, national charities including Place2Be, the Anna Freud Centre for Children and Families and the National Children's Bureau have highlighted the need for 'whole school' and 'whole system' approaches to children's wellbeing in disadvantaged neighbourhoods.

6.2. In light of this, we have proposed to make funding available for partnerships between schools, VCSE organisations and public services to develop 'family zones' to improve the environment for children and families around schools in disadvantaged neighbourhoods. This draws on the approaches developed by Impact on Urban Health and some chains of Academy school across England. A single project along the lines we outline would be able to develop a family zone around a local primary school in a disadvantaged neighbourhood, improving support and the environment for around 1000 children and their families.

6.3. Following discussions with successful initiatives, we are proposing that funding is allocated to partnerships led by the head teacher of a local school within significantly disadvantaged neighbourhoods, which hire local people to play zone manager and coordinator roles, which bring together local parents and community organisations to set direction on a community board, and take an assets based approach to improving the local environment, reflecting what matters to local families and building on the existing resources in the neighbourhood.

7. Adults' mental health

7.1. For adults' mental health, we have committed to improving access to trusted and effective early support for adults in disadvantaged groups facing common mental health challenges, so we reduce the number of adults in disadvantaged groups entering crisis or developing more severe mental health problems. Our research highlighted the lack of trust and connection between many disadvantaged communities and statutory mental health services, reliance on a narrow range of therapeutic approaches, and a lack of culturally appropriate support for some communities. However, a number of small VCSE organisations in south east London are delivering highly effective and low cost support for adults with a wide range of common mental health challenges, including more severe challenges.

7.2. In light of this, we are proposing to target funding specifically on VCSE-led organisations that deliver non-medical, socially oriented support for adults with mental health challenges, with a specific focus on harnessing the resources of peers and service users, helping service users recover agency and self-efficacy, building the components of a good life including friendship, connection and meaningful activity, and supporting service users with social challenges. A single project along the lines we have outlined would allow local VCSE organisations to support around 100 to 150 adults with common mental health challenges each year, with the numbers varying depending on the precise service model and the severity of people's conditions.

7.3. Again, there is a very strong evidence base on the effectiveness of this type of support and its cost effectiveness in comparison with traditional approaches. Our project initiation document cites the evidence of impact of three approaches, Mosaic Clubhouse, Solidarity in a Crisis and Culturally Appropriate Peer Support and Advocacy (CAPSA) although there are many other successful services working along similar lines. As well as being able to avoid admissions into specialist inpatient NHS services, these approaches offer opportunities to avoid inpatient stays or accelerate discharge from inpatient mental health services. Support from Mosaic Clubhouse costs c. £2000 per member per year, in comparison with around £3500 per week for a patient in an NHS mental health ward.

8. Primary care and long-term conditions

8.1. For primary care and long-term conditions, we have committed to delivering proactive and joined-up support for people with long term conditions and complex health and social needs, so more people report a positive experience of care, live independently and live good lives. The national NHS advocates the development of integrated neighbourhood teams to deliver holistic care for people with more complex needs, drawing on international evidence that this can lead to improved quality and better use of scarce resources.

8.2. Our proposal is to make funding available within each of our local care partnerships to support the development of an integrated neighbourhood team focused specifically on delivery of proactive, whole person care for adults at risk of worsening health and wellbeing in disadvantaged neighbourhoods and groups. These projects should focus on developing preventative and proactive approaches for people with complex health or social needs and models that secure substantial efficiencies through teamworking.

8.3. Under our proposals, the ICB would provide development support for a Primary Care Network (PCN) to follow a design and implementation process for developing a model of integrated team working for adults with complex health and social needs, covering a population of around 30,000 to 50,000 people. This would allow each PCN to follow a structured approach to securing the intended benefits of team-based care, complete PDSA cycles and measure impact, as well as sharing learning with each other.

8.4. We are proposing that funding is focused on PCNs with well established relationships and enthusiasm for testing a more integrated, team-based models, openness to new approaches that give equal weight to physical health, mental health and social issues, active partnership working with local VCSE organisations, and commitment to designing team-based approaches in genuine partnership with VCSE organisations and the local community. The funding would not cover the costs of new staff or facilities. This is because the necessary staff already exist within our primary care, community care, mental health and hospital services, as well as within social care and the VCSE. We would look for sites where partners are ready to explore new ways of using these staff to secure the full benefits of team-based care.

9. Selection of projects

9.1. We propose to ask our local care partnerships to work with our learning partners to decide which partnerships or organisations to invest in. These might be partnerships or organisations that are already delivering services that relate to our strategic priorities and want to develop them further or organisations that want to establish new projects in line with our priorities. Our local care partnerships may also wish to pursue a some of these projects together, for example developing a community-led approach to

prevention, support for mums and families with high vulnerabilities and an integrated model of primary and community care within a single neighbourhood.

9.2. In our project initiation documents, we have outlined some of the criteria we believe will be important in selecting appropriate sites. For example, it will be important to select partnerships and organisations which are in a position to mobilise quickly and make rapid progress in 2024, which are enthusiastic about the broad approaches we have identified and are eager to learn together as they implement them.

9.3. As discussed above, we have also identified some minimum criteria for the overall approach across sites. This is important both to ensure that we reflect the existing evidence base and to bring together sites and projects that can learn effectively together. In some cases, these minimum criteria cover features of how care is delivered, for example focusing on a defined neighbourhood. In other cases, the criteria relate to the principles and ethos of projects, for example working in partnership with the VCSE and residents on service design. These minimum criteria are discussed in more detail in the Annex.

9.4. We have drawn on successful services to develop an estimate of overall funding requirements and potential impact of projects under each of our strategic priorities. However, there would be scope for projects to use the funding in different ways, for example to invest in different types of staff or services, providing that the plans were in line with our overall objectives and proposed funding criteria.

10. Cross system learning and evaluation

10.1. As explained above, we propose to use a small proportion of the available resources secure learning partners for each priority. We are excited about the possibility of enabling our sites to draw from the expertise of national charities, VCSE organisations and academy chains who have led the development of effective approaches to prevention, early years and mental health for disadvantaged neighbourhoods. The learning partners' role would be to ensure sites draw from the available evidence, coach sites as the develop and implement their approaches, and bring sites together to share learning and enable faster progress.

10.2. We also propose to identify a single partner from within our system to evaluate all of our strategy projects. Their role would be to measure the impact of the projects in improving outcomes and improving efficiency. Their role would also be to codify sites' models of care and capture qualitative evidence on the characteristics of successful approaches. As well as building our evidence on impact, this should allow us to develop our thinking on how to spread these approaches effectively across our system. (This could either be through investment in new or expanded services or, more likely, supporting existing services to adopt new ways of delivering care.) This work should also inform our thinking on our approach to measuring impact and delivering service change for the longer term.

11. Next Steps

11.1. If the Integrated Care Partnership agrees to these proposals, we will ask the Integrated Care Board to identify available funding for projects to start from Spring / Summer 2024 onwards. We will adapt the proposals to reflect the funding available. If the Partnership and the Board support these proposals, the immediate next steps will be to complete the consideration of funding for these projects in the planning process up to May 2024, to secure our learning partners and to start identifying potential delivery organisations and projects in Quarter 1 2024/25 so that projects can start from Quarter 2 2024/25 onwards.

Figure 4: Summary of next steps

Quarter	Objectives	Key actions
Quarter 4 2023/24 - Quarter 1 2024/25	Identify available resources and learning partners, prepare to select projects	• Identify available funding and division between strategy programmes (potentially up until May 2024 in line with the planning process for 2024/25(• Explore options and identify learning and evaluation partners • Agree minimum criteria for accessing funding for strategy projects • Agree method for selecting participants and allocating resources to them • Agree metrics and outline evaluation approach • Identify learning partners and agree structure for collaborative learning across SEL
Quarter 1-2 2024/25	Selection, design and establishment of strategy projects	• Bring together stakeholders to explain each programme and discuss participation • Invite and assess proposals • Recruitment into roles to deliver strategy projects • Design of overall approaches to each project • Start of implementation of projects • Start of collaborative learning programmes
Quarter 3 - 4 2024/25	Delivery of strategy projects	• Early implementation of projects • PDSA cycles to test impact of changes and enable rapid adaptation • Continuation of structured collaborative learning across sites • Ongoing evaluation focusing initially on approach to design, co-production and transition • Reporting to IC Partnership on progress
Quarters 1 – 4 2025/26	Embedding projects, collating learning and review of impact, decisions on future investment.	• Continuation of iterative improvement across each of the sites • Ongoing collaborative learning across sites • Evaluation to focus on codifying the final approaches developed, the methods used and learning on effective transition, impact and value for money. • Reporting to IC Partnership on progress and impact in time to inform decisions on continuation and spread of these models from 2026/27 onwards.